H.229

Introduced by Committee on Health Care

Date:

Subject: Health; insurance; Catamount Health; premium assistance; chronic care

Statement of purpose: This bill proposes to make corrections and clarifications to the 2006 Health Care Affordability Act and related legislation.

AN ACT RELATING TO CORRECTIONS AND CLARIFICATIONS TO THE HEALTH CARE AFFORDABILITY ACT OF 2006 AND RELATED LEGISLATION

It is hereby enacted by the General Assembly of the State of Vermont:

*** * * Catamount Health Insurance * * ***

Sec. 1. 8 V.S.A. § 4080f(a)(9) is amended to read:

(a) As used in this section:

* * *

(9) "Uninsured" means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur, and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

(A) the individual's private insurance or employer-sponsored coverage ended because of:

(i) loss of employment, unless the employer has terminated its employees for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;

(ii) death of the principal insurance policyholder;

(iii) divorce or dissolution of a civil union;

(iv) no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

(v) no longer ~~qualifying for~~ receiving COBRA, VIPER, or other state continuation coverage; or

(B) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

Sec. 2. 8 V.S.A. § 4080f(c)(6) is added to read:

(6) A health care facility or health care provider who agrees to participate in a Catamount Health network that provides services for a Catamount Health insured shall not balance bill the insured by charging the insured amounts in addition to the reimbursement provided for by the plan's participating provider agreement.

Sec. 3. 8 V.S.A. § 4080f(d)(1) is amended to read:

(d)(1) A carrier shall guarantee acceptance of any uninsured individual for any Catamount Health plan offered by the carrier. A carrier shall also guarantee acceptance of each dependent of an uninsured individual in Catamount Health. An individual who is eligible for Medicare may not purchase Catamount Health. An individual who is eligible for an employer-sponsored insurance plan may not purchase Catamount Health, except as provided for in subdivision (2) of this subsection. Any dispute regarding eligibility shall be resolved by the department in a manner to be determined by rule.

Sec. 4. 8 V.S.A. § 4080f(d)(2) is amended to read:

(2)(A) An individual with income ~~under~~ less than or equal to 300 percent of the federal poverty level who is eligible for an employer-sponsored insurance plan may purchase Catamount Health if:

~~(A)~~(i) the individual's employer-sponsored insurance plan is not an approved employer-sponsored plan under section 1974 of Title 33;

~~(B)~~(ii) enrolling the individual in an approved employer-sponsored plan combined with premium assistance under section 1974 of Title 33 offered by the agency of human services is not cost-effective to the state as compared to enrolling the individual in Catamount Health combined with the assistance under subchapter 3a of chapter 19 of Title 33; or

~~(C)~~(iii) the individual is eligible for employer-sponsored insurance premium assistance under section 1974 of Title 33, but is unable to enroll in the employer's insurance plan until the next open enrollment period.

(B) Decisions by the agency of human services regarding whether an individual's employer-sponsored plan is an approved employer-sponsored plan under section 1974 of Title 33 and decisions by the agency of human services regarding whether enrolling the individual in an approved employer-sponsored plan is cost-effective under section 1974 of Title 33 are matters fully within the discretion of the agency of human services. On appeal pursuant to section 3091 of Title 3, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.

Sec. 5. 8 V.S.A. § 4080f(d)(3) is amended to read:

(3)(A) An individual who loses eligibility for the employer-sponsored premium programs in section 1974 of Title 33 may purchase Catamount Health without being uninsured for 12 months.

(B) An individual who has been enrolled in Medicaid, VHAP, Dr. Dynasaur, or any other health benefit plan authorized under Title XIX or Title XX of the Social Security Act shall not be subject to a 12-month waiting period before becoming eligible for Catamount Health.

Sec. 6. 8 V.S.A. § 4080f(f) is amended to read:

(f)(1) Except as provided for in subdivision (2) of this subsection, the carrier shall pay health care professionals using ~~the Medicare payment methodologies~~ the Medicare fee schedule, at ~~a level~~ an amount ten percent greater than ~~for levels~~ fee schedule amounts paid under the Medicare program in 2006. Payments under this subsection shall be indexed to the Medicare economic index developed annually by the Centers for Medicare and Medicaid Services. The commissioner may approve adjustments to the amounts paid under this section in accordance with a carrier's pay for performance, quality improvement program, or other payment methodologies in accordance with the blueprint for health established under chapter 13 of Title 18.

(2) Payments for hospital services shall be calculated using ~~the Medicare payment methodology~~ a hospital-specific cost-to-charge ratio approved by the commissioner, adjusted for each hospital to ensure payments at 110 percent of the hospital's actual cost for services. The commissioner may use individual hospital budgets established under section 9456 of Title 18 to determine approved ratios under this subdivision. Payments under this subdivision shall be indexed to changes in the Medicare payment rules, but shall not be lower than 102 percent of the hospital's actual cost for services. The commissioner may approve adjustments to the amounts paid under this section in accordance with a carrier's pay for performance, quality improvement program, or other

payment methodologies in accordance with the blueprint for health established under chapter 13 of Title 18.

(3) Payments for chronic care and chronic care management shall meet the requirements in section 702 of Title 18 and section 1903a of Title 33.

(4) If Medicare does not pay for a service covered under Catamount Health, or if the Medicare fee schedule does not set an amount for a service covered under Catamount Health, the commissioner shall establish some other payment amount for such services, determined after consultation with affected health care professionals and insurers.

(5) A carrier offering Catamount Health shall renegotiate existing contracts with health care professionals as necessary in order to pay the reimbursements provided for in this subsection.

(6) All provisions of this subsection shall apply notwithstanding subsections 4513(c), 4584(c), and 5104(b) of this title.

Sec. 7. 8 V.S.A. § 4080f(m) is amended to read:

(m) A letter of intent, proposed rates, and proposed forms shall be filed consistent with the requirements of this section and the rules adopted pursuant to this section.

(1) ~~A carrier shall notify the department that it intends to offer Catamount Health by filing written notice of that intent no later than 30 days after the effective date of the expedited adoption of Catamount Health rules.~~

~~(2)~~ Forms shall be filed initially ~~no later than five months after the letter of intent~~ and upon any change. Forms may not be used unless and until approved as described in this section. The department shall notify the carrier within 45 days whether the form meets the requirements set by statute and rule.

~~(3)~~(2) Rates shall be filed prior to use and ~~initially no later than five months after the letter of intent. Thereafter, rates shall be filed~~ thereafter at least annually on a schedule and in a manner established by rule. The department shall notify the carrier within 45 days whether the rates meet the requirements set by statute and rule.

*** * * Vermont Health Access Plan * * ***

Sec. 8. 33 V.S.A. § 1971 is amended to read:

§ 1971. DEFINITIONS

As used in this subchapter~~,~~:

(1) "Agency" means the agency of human services.

~~(2) "Secretary" means the secretary of human services.~~

~~(3)~~(2) "Office of Vermont health access" means the office administering the Medicaid program for the agency of human services and includes the managed care organization established in section 1901 of this title.

(3) "Secretary" means the secretary of human services.

Sec. 9. 33 V.S.A. § 1973 is amended to read:

§ 1973. VERMONT HEALTH ACCESS PLAN

(a) The agency of human services or its designee shall establish the Vermont health access plan (VHAP) pursuant to a waiver of federal Medicaid law. The plan shall remain in effect as long as a federal 1115 demonstration waiver is granted or renewed.

(b) The purpose of the Vermont health access plan is to provide health care coverage for uninsured or underinsured low income Vermonters. The agency of human services or its designee shall establish rules regarding eligibility and administration of the plan.

(c) An individual who has been enrolled in an approved employer-sponsored insurance plan with premium assistance under section 1974 of this title shall not be subject to a 12-month waiting period before becoming eligible for the Vermont health access plan as provided for in subdivision 1974(d)(1).

(d) An individual who has been enrolled in Catamount Health, with or without premium assistance, shall not be subject to a 12-month waiting period before becoming eligible for the Vermont health access plan.

(e) For purposes of this section, "uninsured" means:

(1) an individual with household income, after allowable deductions, at or below 75 percent of the federal poverty guideline for households of the same size;

(2) an individual who had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application; or

(3) an individual who lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

(A) the individual's coverage ended because of:

(i) loss of employment;

(ii) death of the principal insurance policyholder;

(iii) divorce or dissolution of a civil union;

(iv) no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

(v) no longer receiving COBRA, VIPER, or other state continuation coverage; or

(B) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

*** * * Employer-Sponsored Insurance Premium Assistance * * ***

Sec. 10. 33 V.S.A. § 1974(b) is amended to read:

(b) VHAP-eligible premium assistance.

* * *

(4) An individual who is or becomes eligible for Medicare shall not be eligible for premium assistance under this subsection.

(5) Decisions regarding plan approval and cost-effectiveness are matters fully within the agency's discretion. On appeal pursuant to section 3091 of Title 3, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.

Sec. 11. 33 V.S.A. § 1974(c)(1)(B) is amended to read:

(c) Uninsured individuals; premium assistance.

(1) For the purposes of this subsection:

* * *

(B) "Uninsured" means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

(i) the individual's coverage ended because of:

(I) loss of employment, unless the employer has terminated its employees for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;

(II) death of the principal insurance policyholder;

(III) divorce or dissolution of a civil union;

(IV) no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

(V) no longer ~~qualifying for~~ receiving COBRA, VIPER, or other state continuation coverage; or

(ii) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

Sec. 12. 33 V.S.A. § 1974(c)(2)(B) is amended to read:

(2) An individual is eligible for premium assistance under this subsection if the individual:

* * *

(B) has income ~~under~~ less than or equal to 300 percent of the federal poverty level;

Sec. 13. 33 V.S.A. § 1974(c)(6) is added to read:

(6) Decisions regarding plan approval and cost-effectiveness are matters fully within the agency's discretion. On appeal pursuant to section 3091 of

Title 3, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.

Sec. 14. 33 V.S.A. § 1974(d) is amended to read:

(d)(1) Participation in an approved employer-sponsored insurance plan with premium assistance under this section or Catamount Health shall not disqualify an individual from the Vermont health access plan if an approved employer-sponsored insurance plan or Catamount Health is no longer available to that individual.

(2) An individual who has been enrolled in Medicaid, VHAP, Dr. Dynasaur, or any other health benefit plan authorized under Title XIX or Title XX of the Social Security Act shall not be subject to a 12-month waiting period before becoming eligible for premium assistance to purchase an approved employer-sponsored insurance plan.

(3) Enrollment in Catamount Health, with or without premium assistance, shall not disqualify an individual for premium assistance in connection with an approved employer-sponsored insurance plan.

*** * * Catamount Health Assistance * * ***

Sec. 15. 33 V.S.A. § 1982(2) is amended to read:

As used in this subchapter:

*** * ***

(2) "Uninsured" means an individual who does not qualify for Medicare,

Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

(A) the individual's private insurance or employer-sponsored coverage ended because of:

(i) loss of employment, unless the employer has terminated its employees for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;

(ii) death of the principal insurance policyholder;

(iii) divorce or dissolution of a civil union;

(iv) no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

(v) no longer ~~qualifying for~~ receiving COBRA, VIPER, or other state continuation coverage; or

(B) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

Sec. 16. 33 V.S.A. § 1983(a)(2) is amended to read:

(2) An individual who has access to an employer-sponsored insurance shall be eligible for assistance under this subchapter only if the individual does not have employer-sponsored insurance approved for premium assistance under section 1974 of this title or if it is more cost-effective to the state for the individual to purchase Catamount Health with the assistance under this subchapter than for the state to provide premium assistance under section 1974 of this title. In addition, an individual may receive assistance under this subchapter temporarily until the individual is able to enroll in an approved employer-sponsored plan and receive premium assistance under section 1974. Decisions regarding plan approval and cost-effectiveness are matters fully within the agency's discretion. On appeal pursuant to section 3091 of Title 3, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.

Sec. 17. 33 V.S.A. § 1983(a)(4) is added to read:

(4) An individual who is or becomes eligible for Medicare shall not be eligible for premium assistance under this subchapter.

Sec. 18. 33 V.S.A. § 1983(b) is amended to read:

(b)(1) An individual receiving benefits under Medicaid, the Vermont health access plan, Dr. Dynasaur, or premium assistance for employer-sponsored insurance under section 1974 of this title or any other health benefit plan

authorized under Title XIX or Title XX of the Social Security Act within 12 months of applying for Catamount Health assistance shall not be required to wait 12 months to be eligible.

(2) An individual who has been enrolled in Catamount Health without assistance shall not be subject to a 12-month waiting period before becoming eligible for assistance under this subchapter.

Sec. 19. 33 V.S.A. § 1985(b) is amended to read:

(b) An individual applying for or enrolled in the program established under this subchapter who is aggrieved by an adverse decision of the agency may grieve or appeal the decision under rules and procedures ~~consistent with 42 C.F.R. § 438.402~~ applicable to the Medicaid program.

Sec. 20. 8 V.S.A § 4080(3) is amended to read:

§ 4080. REQUIRED POLICY PROVISIONS

No such policy shall contain any provision relative to notice of claim, proofs of loss, time of payment of claims, or time within which legal action must be brought upon the policy which, in the opinion of the commissioner, is less favorable to the persons insured than would be permitted by the provisions set forth in section 4065 of this title. In addition each such policy shall contain in substance the following provisions:

* * *

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) In the case of an approved employer-sponsored plan under section 1974 of Title 33, a provision that defines as a qualifying event a finding by the agency of human services that an eligible employee, member, or dependent qualifies for premium assistance or is required to participate in the group in accordance with the provisions of section 1974 of Title 33 (employer-sponsored insurance; premium assistance), and that entitles the employee, member, or dependent to a special enrollment period of 30 days from the date of notice of the agency finding.

(5) A provision that the insurer shall not exclude part-time employees and shall offer the same group health benefits to part-time employees as it offers to the employee groups of which the part-time employees would be members if they were full-time employees. The insurer shall offer to include the part-time employees as part of the employer's employee group, at the full rate to be paid by the employer and the employee, at a rate prorated between the employer and the employee or at the employee's expense. "Part-time employee" means any employee who works a minimum of at least 17 1/2 hours per week.

*** * * Chronic Care * * ***

Sec. 21. 18 V.S.A. § 702(b)(1) is amended to read:

(b)(1) The commissioner shall establish an executive committee to advise the commissioner on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall consist of no fewer than 10 individuals, including a representative from the department of banking, insurance, securities, and health care administration; the office of Vermont health access; the Vermont medical society; ~~the Vermont program for quality in health care~~ a statewide quality assurance organization; the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine profession; and a primary care professional serving low income or uninsured Vermonters.

Sec. 22. 33 V.S.A. § 1903a(c)(7) is amended to read:

(c) The chronic care management program shall be designed to include:

* * *

(7) payment to the care management organization which would put all or a portion of the care management organization's fee at risk if the management is not successful in reducing costs to the state;

Sec. 23. 33 V.S.A. § 1903a(f) is added to read:

(f) The terms used in this section shall have the meanings defined in section 701 of Title 18.

* * * **VITL** * * *

Sec. 24. 22 V.S.A. § 903 is added to read:

§ 903. HEALTH INFORMATION TECHNOLOGY

(a) The commissioner shall facilitate the development of a statewide health information technology plan that includes the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. The plan shall include standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, and, overall, a more efficient and less costly means of delivering quality health care in Vermont.

(b) The health information technology plan shall:

(1) support the effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvements;

(2) educate the general public and health care professionals about the value of an electronic health infrastructure for improving patient care;

(3) promote the use of national standards for the development of an

interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;

(4) propose strategic investments in equipment and other infrastructure elements that will facilitate the ongoing development of a statewide infrastructure;

(5) recommend funding mechanisms for the ongoing development and maintenance costs of a statewide health information system;

(6) incorporate the existing health care information technology initiatives in order to avoid incompatible systems and duplicative efforts;

(7) integrate the information technology components of the blueprint for health established in chapter 13 of Title 18, the global clinical record and all other Medicaid management information systems being developed by the office of Vermont health access, information technology components of the quality assurance system, the program to capitalize electronic medical record systems in primary care practices with loans and grants, and any other information technology initiatives coordinated by the secretary of administration pursuant to section 2222a of Title 3; and

(8) address issues related to data ownership, governance, and confidentiality and security of patient information.

(c)(1) The commissioner shall contract with the Vermont information

technology leaders (VITL), a broad-based health information technology advisory group that includes providers, payers, employers, patients, health care purchasers, information technology vendors, and other business leaders, to develop the health information technology plan, including applicable standards, protocols, and pilot programs. In carrying out their responsibilities under this section, members of VITL shall be subject to conflict of interest policies established by the commissioner to ensure that deliberations and decisions are fair and equitable.

(2) VITL shall be designated in the plan to operate the exclusive statewide health information exchange network for this state, notwithstanding the provisions of subsection (g) of this section requiring the recommendation of the commissioner and the approval of the general assembly before the plan can take effect. Nothing in this section shall impede local community providers from the exchange of electronic medical data.

(d) The following persons shall be members of VITL:

(1) the commissioner, who shall advise the group on technology best practices and the state's information technology policies and procedures, including the need for a functionality assessment and feasibility study related to establishing an electronic health information infrastructure under this section;

(2) the director of the office of Vermont health access or his or her

designee;

(3) the commissioner of health or his or her designee; and

(4) the commissioner of banking, insurance, securities, and health care administration, or his or her designee.

(e) On or before July 1, 2006, VITL shall initiate a pilot program involving at least two hospitals using existing sources of electronic health information to establish electronic data sharing for clinical decision support, pursuant to priorities and criteria established in conjunction with the health information technology advisory group.

(1) Objectives of the pilot program shall include:

(A) supporting patient care and improving quality of care;

(B) enhancing productivity of health care professionals and reducing administrative costs of health care delivery and financing;

(2) Objectives of the pilot program may include:

(A) determining whether and how best to expand the pilot program on a statewide basis;

(B) implementing strategies for future developments in health care technology, policy, management, governance, and finance; and

(C) ensuring patient data confidentiality at all times.

(f) The standards and protocols developed by VITL shall be no less stringent than the "Standards for Privacy of Individually Identifiable Health

Information" established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments. In addition, the standards and protocols shall ensure that there are clear prohibitions against the out-of-state release of individually identifiable health information for purposes unrelated to treatment, payment, and health care operations, and that such information shall under no circumstances be used for marketing purposes. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail.

(g) On or before January 1, 2007, VITL shall submit to the commission on health care reform, the secretary of administration, the commissioner, the commissioner of banking, insurance, securities, and health care administration, the director of the office of Vermont health access, and the general assembly a preliminary health information technology plan for establishing a statewide, integrated electronic health information infrastructure in Vermont, including specific steps for achieving the goals and objectives of this section. A final plan shall be submitted July 1, 2007. The plan shall include also recommendations for self-sustainable funding for the ongoing development, maintenance, and replacement of the health information technology system. Upon recommendation by the commissioner and approval by the general assembly, the plan shall serve as the framework within which certificate of

need applications for information technology are reviewed under section 9440b of Title 18 by the commissioner.

(h) Beginning January 1, 2006, and annually thereafter, VITL shall file a report with the commission on health care reform, the secretary of administration, the commissioner, the commissioner of banking, insurance, securities, and health care administration, the director of the office of Vermont health access, and the general assembly. The report shall include an assessment of progress in implementing the provisions of this section, recommendations for additional funding and legislation required, and an analysis of the costs, benefits, and effectiveness of the pilot program authorized under subsection (e) of this section, including, to the extent these can be measured, reductions in tests needed to determine patient medications, improved patient outcomes, or reductions in administrative or other costs achieved as a result of the pilot program. In addition, VITL shall file quarterly progress reports with the secretary of administration and the health access oversight committee and shall publish minutes of VITL meetings and any other relevant information on a public website.

(i) VITL is authorized to seek matching funds to assist with carrying out the purposes of this section. In addition, it may accept any and all donations, gifts, and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof, and from any

person, firm, or corporation for any of its purposes and functions under this section and may receive and use the same, subject to the terms, conditions, and regulations governing such donations, gifts, and grants.

(j) The commissioner, in consultation with VITL, may seek any waivers of federal law, of rule, or of regulation that might assist with implementation of this section.

(k) The commissioner, in collaboration with VITL and other departments and agencies of state government, shall establish a loan and grant program to provide for the capitalization of electronic medical records systems at primary care practices. Health information technology acquired under a grant or loan authorized by this section shall comply with data standards for interoperability adopted by VITL and the state health information technology plan. An implementation plan for this loan and grant program shall be completed by December 1, 2007, and shall be consistent with the state health information technology plan.

* * * **Multi-payer Database** * * *

Sec. 25. 18 V.S.A. § 9410(h)(3)(C) is amended to read:

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the commissioner may prescribe by regulation, the Vermont information technology leaders (VITL) shall have access to the database for use in the development of a statewide health information technology plan

pursuant to section ~~9417 of this title~~ 903 of Title 22, and the Vermont program for quality in health care shall have access to the database for use in improving the quality of health care services in Vermont. The commissioner's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

Sec. 26. MULTI-PAYER DATA COLLECTION PROGRAM FUNDING

On or before January 15, 2008, the commissioner of banking, insurance, securities, and health care administration shall report to the governor and the general assembly with recommendations for annual financial support for the multi-payer health care data collection program authorized by section 9410 of Title 18.

*** * * Employer Assessment * * ***

Sec. 27. 21 V.S.A. chapter 25 is amended to read:

CHAPTER 25. EMPLOYERS' HEALTH CARE

~~PREMIUM~~ FUND CONTRIBUTION

§ 2001. PURPOSE

For the purpose of more equitably distributing the costs of health care to uninsured residents of this state an employers' health care ~~premium~~ fund contribution is established to provide a fair and reasonable method for sharing health care costs with employers who do not offer their employees health care coverage.

§ 2002. DEFINITIONS

For the purposes of this chapter:

(1) "Employee" means an individual over the age of majority employed full-time or part-time by an employer to perform services in this state.

(2) "Employer" means a person who is required under subchapter 4 of chapter 151 of Title 32 to withhold income taxes from payments of income with respect to services, but shall not include the government of the United States.

(3) "Full-time equivalent" or "FTE" means the number of employees expressed as the number of employee hours worked during a calendar quarter divided by 520. "Full-time equivalent" shall not include any employee hours attributable to a seasonal employee of an employer who offers health care coverage to all of its regular full-time employees, provided that the seasonal employee has health care coverage under either a private or a public plan.

(4) "Seasonal employee" means an employee who:

(A) works for an employer for fewer than 20 weeks in a calendar year; and

(B) works in a job scheduled to last 20 weeks or less.

(5) "Uncovered employee" means:

(A) an employee of an employer who does not offer to pay any part of the cost of health care coverage for its employees.

(B) an employee who is not eligible for health care coverage offered by an employer to any other employees; or

(C) an employee who is offered and is eligible for coverage by the employer but elects not to accept the coverage and has no other health care coverage under either a private or public plan.

§ 2003. ~~PREMIUM~~ HEALTH CARE FUND CONTRIBUTION ASSESSMENT

(a) The commissioner of labor shall assess and an employer shall pay a quarterly health care ~~premium~~ fund contribution for each full-time equivalent uncovered employee employed during that quarter in excess of:

(1) eight full-time equivalent employees in fiscal years 2007 and 2008;

(2) six full-time equivalent employees in fiscal year 2009; and

(3) four full-time equivalent employees in fiscal years 2010 and thereafter.

(b) For any quarter in fiscal years 2007 and 2008, the amount of the health care ~~premium~~ fund contribution shall be $91.25 for each full-time equivalent employee in excess of eight. For each fiscal year after fiscal year 2008, the number of excluded full-time equivalent employees shall be adjusted in accordance with subsection (a) of this section, and the amount of the health care ~~premium~~ fund contribution shall be adjusted by a percentage equal to any percentage change in premiums for Catamount Health for that fiscal year.

(c) ~~Premium~~ Health care fund contribution assessments under this chapter shall be determined on a calendar quarter basis, due and payable 30 days after the close of each quarter. Late filings, late payments and underpayments of the ~~premium~~ health care fund contribution assessments due shall be subject to the same fees, interest and penalties as pertain to contributions for unemployment compensation under chapter 17 of this title. Liability for contributions, payments, penalties, interest and costs imposed under this section may be collected and enforced in a civil action maintained under sections 1334 of this title, and under the procedures authorized by section 1336 of this title. The commissioner shall establish rules for the administration and collection of ~~premiums~~ health care fund contributions under this chapter. To the extent feasible any reports required of employers under this chapter shall be combined with other reports and information collected from employers by the department of labor.

(d) Revenues from the ~~premiums~~ health care fund contributions collected shall be deposited into the Catamount Fund established under 33 V.S.A. § 1981 for the purpose of financing health care coverage under Catamount Health assistance, as provided under subchapter 3a of chapter 19 of Title 33.

Sec. 28. 21 V.S.A. chapter 5, subchapter 10A is added to read:

Subchapter 10A. Health Coverage Status

§ 510. HEALTH COVERAGE STATUS DISCRIMINATION PROHIBITED

(a) For the purposes of this section:

(1) "Employee" shall have the same meaning as in section 2002 of this title.

(2) "Employer" shall have the same meaning as in section 2002 of this title.

(b) No employer or employment agency, or an agent of either, shall inquire about the health coverage status of a job applicant or in any way discriminate among applicants on the basis of health coverage status. Nothing in this section shall prevent an employer from informing an applicant about the employer's health coverage benefits. In addition, nothing in this section shall prevent an employer from inquiring about the health coverage status of an employee to enable the employer to determine the number of uncovered employees pursuant to Chapter 25 of Title 21.

(c) An applicant aggrieved by a violation of this section may bring an action in the superior court of the county in which the violation is alleged to have occurred. If the court finds that the employer has violated subsection (b) of this section, the court shall order as many of the following as appropriate:

(A) payment of lost wages, benefits, and other remuneration;

(B) any appropriate injunctive relief;

(C) compensatory damages;

(D) punitive damages;

(E) attorney fees; or

(F) any other appropriate relief.

* * * Immunizations * * *

Sec. 29. 18 V.S.A. § 1130(b) is amended to read:

(b) To the extent allowed by the appropriation, the department shall provide payment for any Vermont resident to receive immunizations without cost to the individual, except that individuals enrolled in Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, or any federal health insurance or federal program covering immunizations shall receive coverage under those programs. ~~The department shall be the secondary payer to Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, and any federal health insurance or federal program covering immunizations.~~

Sec. 30. 18 V.S.A. § 9408a is amended to read:

§ 9408A. UNIFORM PROVIDER CREDENTIALING

* * * *

(b) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH), or a similar,

nationally recognized form prescribed by the commissioner, in electronic or paper format, which must be used beginning January 1, 2007 by an insurer or a hospital that performs credentialing. The commissioner may grant a hospital an extension to the implementation date for up to one year.

Sec. 31. REPEAL

The following are repealed:

(1) Sec. 315 of No. 215 of the 2005 Adj. Sess. (2006).

(2) 18 V.S.A. § 9417 (health information technology).